MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES
DOCUMENTATION FOR MEDICAL NEEDS FORMULA ISSUANCE

Section A. Medical Needs Formula Request – Health Care Provider Use Only

Health care provider must complete Section A and either fax or give this form to the participant to bring to the local WIC provider.

Infant Formulas:

The participant must have a medical condition determined by a physician or nurse practitioner. Additionally, two contract formulas must be tried, prior to issuing a non-contract brand formula.

Exempt Infant Formulas and Medical Foods:

The participant must have a medical condition that contraindicates the use of a contract infant formula as determined by a physician or nurse practitioner.

WIC Contract/Non-Contract Infant Formulas

Contract	Non-Contract
▪ Enfamil LIPIL with Iron ▪ ProSobee LIPIL ▪ LactoFree LIPIL ▪ Gentlease LIPIL	▪ Similac (Ross) ▪ Good Start (Nestlė) ▪ Store brands

NAME OF PARTICIPANT	DATE OF BIRTH	NAME OF PARENT/CARETAKER

PRESCRIBED FORMULA	DAILY AMOUNT [optional]	LENGTH OF TIME REQUESTED
		☐ 1 MO. ☐ 2 MO. ☐ 3 MO. ☐ 4 MO.

DIAGNOSIS ☐ GERD ☐ PREMATURITY ☐ FAILURE TO THRIVE ☐ PROTEIN ALLERGY ☐ MALABSORPTION

DESCRIBE OTHER DIAGNOSIS, REACTIONS, MEDICAL CONDITIONS AND/OR SPECIAL INSTRUCTIONS AS NEEDED:

NAME OF PHYSICIAN OR NURSE PRACTITIONER (PRINT)	☐ PHYSICIAN ☐ NURSE PRACTITIONER	PHONE NUMBER

SIGNATURE OF PHYSICIAN OR NURSE PRACTITIONER	DATE

SECTION B. LOCAL WIC PROVIDER USE ONLY

FORMULA INTAKE HISTORY

FORMULA USED				
LENGTH OF TIME	___ DAYS __ WEEKS	___ DAYS __ WEEKS	___ DAYS __ WEEKS	___ DAYS __ WEEKS
INFORMATION REPORTED	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ __________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ __________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ __________	☐ CONSTIPATION ☐ DIARRHEA ☐ GAS ☐ PROJECTILE VOMITING ☐ RASH ☐ SPITTING UP ☐ OTHER _ __________

CHECK REASON(S) FOR REQUESTING READY-TO-FEED/USE.

☐ POOR WATER QUALITY
☐ POOR REFRIGERATION
☐ MIXING/DILUTION DIFFICULTY
☐ TUBEFEEDING
☐ PRODUCT IS ONLY AVAILABLE IN READY-TO-FEED/USE
☐ OTHER ____

☐ APPROVED

☐ DISAPPROVED

DATE:

MONTH(S) FORMULA APPROVED

IF DISAPPROVED, WAS HEALTH CARE PROVIDER CONTACTED? ☐ YES ☐ NO

REASON FOR DISAPPROVAL:

SIGNATURE OF APPROVAL AUTHORITY	☐ RD ☐ NUTRITIONIST ☐ RN

SECTION C. COMPLETE THIS SECTION WHEN LWP RECEIVE APPROVAL FROM THE STATE OFFICE.

NAME OF STATE NUTRITIONIST	DATE APPROVED	☐ RECEIVED AN APPROVAL LETTER AND ATTACHED WITH THIS FORM.